Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Albert Evans a prisoner at HMP Altcourse on 30 December 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Albert Evans died in hospital on 30 December 2018 from septic arthritis, caused by a bacterial infection, while a prisoner at HMP Altcourse. He was 74 years old. I offer my condolences to Mr Evans' family and friends.

I am not satisfied that the care Mr Evans received at Altcourse was equivalent to that which he could have expected to receive in the community. Mr Evans had chronic eczema, which repeatedly became infected. Although healthcare staff prescribed antibiotics and creams, they never carried out wound swabs to identify the cause of the infection and no care plans to manage Mr Evans' skin condition were put in place.

I am also concerned that Mr Evans was restrained when he was taken to hospital. It was not justified by an appropriate risk assessment that took into account Mr Evans' age and poor health.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister
Prisons and Probation Ombudsman **August 2019**

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Summary

Events

1. On 28 July 2016, Mr Albert Evans was recalled to custody for breaching his licence conditions. He was sent to HMP Altcourse.

2. Mr Evans had chronic eczema, which repeatedly became infected. He was prescribed antibiotics and creams when necessary.

3. On 24 November 2018, an officer asked healthcare staff to see Mr Evans in his cell as he was unwell. A prison nurse attended and assessed him. She noted that he had a swollen, hot elbow and was passing blood in his urine. She said that he needed to go to hospital to be assessed further and requested a non-emergency ambulance. Mr Evans was diagnosed with sepsis (a serious life-threatening infection). He was treated in hospital for five weeks but his condition deteriorated and on 30 December, at 9.55am, Mr Evans died.

4. The hospital gave Mr Evans' cause of death as septic arthritis (joint infection) caused by streptococcus bacteraemia (a bacterial infection). It also listed an acute kidney injury (severe kidney infection).

Findings

5. The clinical reviewer found that the care Mr Evans received at Altcourse was not equivalent to that which he could have expected to receive in the community.

6. Mr Evans had had infected eczema over a long period of time. However, there is no evidence that a wound swab was ever taken to determine the cause of the infection. There were also no care plans in place to monitor Mr Evans' skin condition.

7. We are also concerned that restraints were used when Mr Evans was taken to hospital. Healthcare input to the escort risk assessment was inadequate and there was no evidence that the authorising manager had taken Mr Evans' physical health into account when deciding to authorise the use of restraints.

Recommendations

- The Head of Healthcare should ensure that nurses caring for patients with skin conditions have the necessary skills to deliver high quality care.

- The Head of Healthcare should ensure that all wounds are properly assessed and appropriate care plans are put in place.

- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

- The Director should revise the prison's escort risk assessment form to ensure that it requires:
    - healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
    - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

9. The investigator obtained copies of relevant extracts from Mr Evans' prison and medical records.

10. The investigator interviewed three members of staff and one prisoner at Altcourse on 13 February 2019.

11. NHS England commissioned a clinical reviewer to review Mr Evans' clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.

12. We informed HM Coroner for Liverpool of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Evans' daughter, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any issues.

14. Mr Evans' family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Altcourse

16. HMP Altcourse is a local prison in Liverpool, which takes prisoners from courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 remanded and sentenced adults and young men. G4S manages the prison and provides primary healthcare services. There is an inpatient unit with 12 beds and 24-hour healthcare cover.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Altcourse was in November 2017. Inspectors reported that there was a range of appropriate primary care services, prisoners received responsive care and staffing levels were satisfactory. Continuity of care had been adversely affected after the termination of the previous GP contract and the use of locum cover, but this had recently improved with use of a regular agency. Care plans were in place for prisoners with long term conditions, but they were sometimes inadequately reviewed. The inpatient unit required improvement.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2018, the IMB reported that a new GP contract had recently been agreed which they hoped would reduce the current eight week waiting time to see a doctor for non-urgent appointments. The board highlighted the poor condition of the waiting room for vulnerable prisoners, which they described as airless, cramped and generally unfit for purpose.

19. On a positive note the board highlighted a dramatic reduction in recent months of healthcare complaints together with the introduction of a healthcare 'forum' which gives prisoners the opportunity to raise concerns. They also noted the benefits of health promotion and prevention activity, including stress awareness, HIV, blood pressure, autism and mental health awareness and bowel cancer screening.

Previous deaths at HMP Altcourse

20. Mr Evans was the 11th prisoner to die at Altcourse since December 2016. Of the previous deaths, three were self-inflicted and seven were from natural causes. There have been no deaths since. We have previously made a recommendation to Altcourse about the inappropriate use of restraints.

Key Events

21. On 28 July 2016, Mr Albert Evans was recalled to prison for breaching his licence conditions. He was sent to HMP Altcourse

22. Mr Evans, who was aged 72 when he returned to prison custody, had chronic eczema (a condition that causes the skin to become itchy, red, dry and cracked). Healthcare staff prescribed appropriate creams when his eczema flared up but Mr Evans was not always consistent about attending GP and clinic appointments for assessment and review of his eczema.

23. On 9 August 2018, a prison GP examined Mr Evans' foot and back and noted eczema patches. He thought that this was likely to be a bacterial infection and prescribed clarithromycin tablets (an antibiotic used to treat bacterial infections). There is no evidence that a wound swab (a test that would have helped to identify the cause of infection and guide the treatment of any identified bacteria or virus) was requested or taken.

24. On 22 August, a nurse saw Mr Evans when he attended to collect his medication. She noted he appeared to be very upset due to a flare up of his eczema which was cracked and weeping on his foot and was extensive across his back. The nurse made an appointment for him to see a prison GP on 24 August. However, due to an incident on the wing he could not attend.

25. On 6 September, Mr Evans was seen by a prison GP. He noted eczema all over Mr Evans' body, especially his back. He prescribed creams and clarithromycin to treat an infection on the left foot and right inner ankle. He also requested that Mr Evans was assessed at the dressings clinic. Again, no wound swab was requested and there is no evidence that any care plans were in place. Mr Evans did not attend his appointment at the dressings clinic.

26. On 1 October, a nurse saw Mr Evans because officers were concerned about the condition of his foot. Mr Evans said he was in a lot of pain. The nurse gave him paracetamol and made an emergency GP appointment. A prison GP saw him the same day. He noted that Mr Evans' eczema was sore, crusted and weeping around the ankle and feet. He prescribed antibiotics and a strong steroid cream. There is no evidence that a wound swab was requested or taken.

27. Mr Evans failed to attend GP appointments on 6 and 16 October, but he did attend on 17 October. The GP noted a left foot eruption (break out) of crusted vesicles (small blisters) with a possible element of shingles (a virus). He prescribed anti-viral tablets and foot soaks in potassium permanganate (an antiseptic and antifungal treatment). No wound swab was taken. On 23 October, the GP made an urgent referral to a hospital dermatologist (skin specialist).

28. Mr Evans attended the dressings clinic on 11 November and a wound plan was agreed, but no wound swab was taken.

29. On 22 November, Mr Evans was seen in the morning by a nurse. Mr Evans complained that he had pain in his right elbow, but he was not cooperative with assessments and refused to be examined. He stated that he would take pain killers in the afternoon. He said that it had been painful for more than a year and

that he had not had any recent injury or fall. The nurse noticed that the elbow was swollen. He told a senior nurse and an urgent GP appointment was booked for the following day.

30. On the evening of 22 November, Mr Evans' health deteriorated. An officer went to check on Mr Evans and noted that he appeared to be in a lot of pain in his right elbow. She was so concerned that she asked healthcare staff to attend. She later documented that they refused. At interview, the Head of Healthcare said she knew nothing of this incident and said that the expectation would be that a nurse would always attend if requested to do so by an officer.

31. On 23 November, an officer called healthcare staff as she was worried about Mr Evans. A nurse attended Mr Evans' cell and noted that he had passed blood in his urine. The nurse called a senior nurse, who advised that Mr Evans should go to the healthcare unit for an urgent GP appointment. Mr Evans was taken to see a prison GP. Mr Evans told the GP that he had hit his elbow the day before. The GP noted restricted movement and obvious swelling to the elbow. He prescribed clarithromycin and co-codamol for pain relief. He also provided Mr Evans with a pot to give a urine sample the following morning.

32. On 24 November, an officer asked healthcare staff to attend Mr Evans' cell again as he was still unwell. A nurse went to Mr Evans' cell and assessed him, she noticed that his right elbow was swollen and hot to touch. He appeared to be generally unwell and had again passed blood in his urine. The nurse decided that he needed to be seen in hospital and requested a non-urgent ambulance. Mr Evans was taken to Fazakerley Hospital, escorted by two prison officers who used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer and the other to the prisoner.) Mr Evans was admitted to hospital and diagnosed with sepsis (a serious life-threatening infection). He was treated for this with intravenous (directly into a vein) antibiotics.

33. Prison healthcare staff regularly kept in touch with the hospital and visited Mr Evans to offer support. On 16 December, a hospital nurse informed the prison that Mr Evans was very unwell, he had renal failure and multiple medical problems. Over the next two weeks his condition deteriorated further. On 30 December, at 9.55am, Mr Evans died.

Contact with Mr Evans' family

34. On 11 December, due to Mr Evans' deteriorating condition, the prison appointed a prison manager as the family liaison officer (FLO). He checked Mr Evans' prison record and found that there were no next of kin details. He contacted the police and Mr Evans' offender supervisor to try to find a next of kin. North Wales police managed to trace Mr Evans' daughter. She informed the prison that she was happy for the coroner to arrange the funeral.

35. The prison paid for Mr Evans' funeral in line with national guidelines. The funeral took place on 30 January.

Support for prisoners and staff

36. After Mr Evans' death, a prison manager debriefed the staff involved in Mr Evans' care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

37. The prison posted notices informing other prisoners of Mr Evans' death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Evans' death.

Cause of death

38. The coroner accepted the cause of death provided by the hospital and no post-mortem examination was conducted. The hospital recorded Mr Evans' cause of death as septic arthritis (joint infection), caused by streptococcus bacteraemia (a bacterial infection). It also listed acute kidney injury (sudden damage, such as severe kidney infection).

Findings

Clinical Care

39. The clinical reviewer found that the care Mr Evans received at Altcourse was not equivalent to that which he could have expected to receive in the community. The clinical reviewer was concerned that Mr Evans was seen on numerous occasions with infected eczema and although he was prescribed with oral antibiotics, antivirals and creams, there is no evidence that any attempts were made to identify the nature of the infection, and no wound swabs were taken.

40. Mr Evans often refused to engage with healthcare and did not always attend appointments that were made for him, which limited the treatment he received. However, if clear care plans had been put in place it may have improved the care that Mr Evans received. Also, if an earlier referral had been made to an appropriate specialist he may have had some relief from his symptoms. While this may not have altered the outcome, it would have evidenced that healthcare staff were compliant with National Institute for Health and Care Excellence (NICE) guidelines.

41. We make the following recommendations:

    The Head of Healthcare should ensure that nurses caring for patients with skin conditions have the necessary skills to deliver high quality care.

    The Head of Healthcare should ensure that all wounds are properly assessed and appropriate care plans are put in place.

Restraints, security and escorts

42. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and considers the prisoner's health and mobility.

43. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

44. Mr Evans was taken to hospital and restrained using an escort chain. The risk assessment does not demonstrate that the authorising manager took into account Mr Evans' health or mobility at the time. He did not consider whether other options might have been more appropriate given Mr Evans' state of health.

45. When the manager was interviewed he said that he did not go and see Mr Evans to assess him, he completed the risk assessment based on the information that he had been given. He said that this was the normal procedure. There was also little input from healthcare staff who had simply ticked a box to say that they had

no objection to the use of restraints. We therefore make the following recommendations:

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Director should revise the prison's escort risk assessment form to ensure that it requires:

- **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**
- **prison staff to show that they have taken this information into account in when assessing prisoners.**

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